

**Affidavit of Records Custodian of
The Back & Neck Institute**

STATE OF TEXAS

§

§

COUNTY OF EL PASO

§

Before me, the undersigned authority, personally appeared Lucia Ornela, who, being by me duly sworn, deposed as follows: (Custodian of Records Name)

My name is Lucia Ornela I am of sound mind and capable of making this affidavit, and personally acquainted with the facts herein stated.

I am the custodian of records for **The Back & Neck Institute**. Attached to this affidavit are records that provide an itemized statement of the service and the charge for the service that **The Back & Neck Institute** provided to DAWN CORDERO on **October 11, 2016 to Present**, the attached records are part of this affidavit.

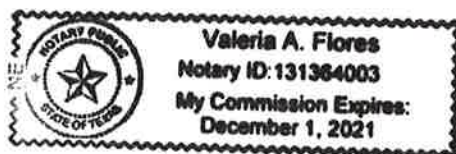
The attached records are kept by **The Back & Neck Institute** in the regular course of business, and it was the regular course of business of **The Back & Neck Institute** for an employee or representative of for **The Back & Neck Institute**, with knowledge of the service provided, to make the record or transmit information to be included in the record. The records were made in the regular course of business at or near the time reasonably soon after the time the service was provided. The records are the original or duplicate of the original.

The services provided were necessary and the amount charged for the services was reasonable at the time and place that the services were provided.

The total amount paid for the services was \$ 0 and the amount currently unpaid but which for **The Back & Neck Institute** has a right to be paid after any adjustments or credits is \$ 18,490.00

[Signature]
Affiant (Custodian of Records Signature)

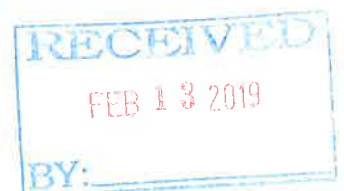
SWORN TO AND SUBSCRIBED before me on the 4 day of June, 2018



[Signature]
Notary Public, State of Texas

Notary's printed name: Valeria Flores My commission expires: 12/01/2021

EXHIBIT 2





FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#DoD#) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HOWDYS	
3. PATIENT'S BIRTH DATE MM DD YY 07 05 1995 M F <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 12460 MONTWOOD DR	
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE	
CITY EL PASO STATE TX		CITY STATE	
ZIP CODE 79928 TELEPHONE (Include Area Code) ()		ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 10/17/17		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 07 05 1995 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL 431		15. OTHER DATE MM DD YY 09 28 17 QUAL 454	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M24852 B. M79605 C. M7062 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 09 28 17 09 28 17 11 99245 ABC 750 00 1 NPI 1356303150			
2 09 28 17 09 28 17 11 73502 LT ABC 250 00 1 NPI 1356303150			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 10/17/17 DATE		28. TOTAL CHARGE \$ 1000.00 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use	
32. SERVICE FACILITY LOCATION INFORMATION THE BACK NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.		33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b. OBMDK4281TX	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
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CITY EL PASO					STATE TX					7. INSURED'S ADDRESS (No., Street) 12460 MONTWOOD DR					8. RESERVED FOR NUCC USE																								
ZIP CODE 79928					TELEPHONE (Include Area Code) ()					CITY					STATE																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)																													
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
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1 06 22 18 06 22 18 11 99215 ABC 500.00 1 NPI 1356303150																				23. PRIOR AUTHORIZATION NUMBER																			
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FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
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CITY EL PASO										CITY									
STATE TX										STATE									
ZIP CODE 79928										ZIP CODE									
TELEPHONE (Include Area Code) ()										TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
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25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) CORDA005 137836 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 08/07/18 DATE										32. SERVICE FACILITY LOCATION INFORMATION BASSETT SURGERY CENTER 6211 EDMERE STE2 EL PASO TX 79925-3413 a. 1477517316									
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FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
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c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 11/27/18			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL 431		15. OTHER DATE QUAL 454 MM DD YY 09 28 17	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA		17a. OE MDK4281TX 17b. NPI 1356303150	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <input type="checkbox"/>			
A. <u>M24852</u> B. <u>M79605</u> C. <u>M7062</u> D. <u> </u> E. <u> </u> F. <u> </u> G. <u> </u> H. <u> </u> I. <u> </u> J. <u> </u> K. <u> </u> L. <u> </u>			
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE	
C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E. DIAGNOSIS POINTER		F. \$ CHARGES	
G. DAYS OR UNITS		H. EPSDT Family Plan	
I. ID. QUAL		J. RENDERING PROVIDER ID. #	
11 01 18 11 01 18 11		72148 ABC 2250 00 1 NPI 1356303150	
25. FEDERAL TAX I.D. NUMBER 742930387 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. CORDA005 140943	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 225000	
29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 11/27/18 DATE		32. SERVICE FACILITY LOCATION INFORMATION THE BACK NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	
33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.			



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA B/L LUNG (ID#) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN										3. PATIENT'S BIRTH DATE MM DD YY 07 05 1995 M <input type="checkbox"/> F <input checked="" type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN																			
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR																			
CITY EL PASO					STATE TX					CITY EL PASO					STATE TX																								
ZIP CODE 79928					TELEPHONE (Include Area Code) ()					ZIP CODE 79928					TELEPHONE (Include Area Code) ()																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY 07 05 1995 M <input type="checkbox"/> F <input checked="" type="checkbox"/>																			
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 12/11/18																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL 431										15. OTHER DATE QUAL 454 MM DD YY 09 28 17										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR ROBERT E URREA MDPA										17a. OB MDK4281TX 17b. NPI 1356303150										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M24852 B. M79605 C. M7062 D. E. F. G. H. I. J. K. L. ICD Ind. 23. PRIOR AUTHORIZATION NUMBER										F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. OVAL J. RENDERING PROVIDER ID. #																													
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. OVAL J. RENDERING PROVIDER ID. #																													
11 14 18 11 14 18 11 99215 ABC 500 00 1 NPI 1356303150																																							
25. FEDERAL TAX I.D. NUMBER 742930387 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. CORDA005 141510										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																			
28. TOTAL CHARGE \$ 500.00										29. AMOUNT PAID \$										30. Rsvd for NUCC Use																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 12/11/18 DATE										32. SERVICE FACILITY LOCATION INFORMATION THE BACK NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.										33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.																			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

CARRIER →

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA					
1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicald#)		TRICARE <input type="checkbox"/> (ID#/DoD#)	
		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	
				FECA BUX LUNG <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)	
				OTHER <input checked="" type="checkbox"/> (ID#)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN				3. PATIENT'S BIRTH DATE MM DD YY 07 05 1995 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
CITY EL PASO		STATE TX		7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR	
ZIP CODE 79928		TELEPHONE (Include Area Code) ()		CITY EL PASO	
				STATE TX	
				ZIP CODE 79928	
				TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					
SIGNATURE ON FILE _____ DATE 01/09/19					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 10 11 16 QUAL 431					
15. OTHER DATE QUAL 454 MM DD YY 09 28 17					
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA					
17a. OB MDK4281TX					
17b. NPI 1356303150					
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X					
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M545 B. C. D. E. F. G. H. I. J. K. L.					
22. RESUBMISSION CODE ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPDS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPISODE Family Plan I. ID. QUAL J. RENDERING PROVIDER ID.#					
12 20 18 12 20 18 24 64483 A 5000 00 1 NPI 1356303150					
12 20 18 12 20 18 24 64450 59 A 1000 00 1 NPI 1356303150					
12 20 18 12 20 18 24 72100 26 59 A 500 00 1 NPI 1356303150					
25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 <input type="checkbox"/> X					
26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt claims, see back) CORDA005 142404 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
28. TOTAL CHARGE \$ 650000 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DESIGNS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 01/09/19					
32. SERVICE FACILITY LOCATION INFORMATION BASSETT SURGERY CENTER 6211 EDMERE STE2 EL PASO TX 79925-3413 a. 1477517316 b.					
33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.					



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (MemberID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN	
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR		7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR	
CITY EL PASO		CITY EL PASO	
STATE TX		STATE TX	
ZIP CODE 79928		ZIP CODE 79928	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M F X	
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete Items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 01/16/19		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 431 10 11 16		15. OTHER DATE MM DD YY QUAL 454 09 28 17	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR ROBERT E URREA MDPA		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M24852 B. M79605 C. M7062 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 01 03 19 01 03 19 11 99215 ABC 500.00 1 NPI 1356303150			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 X		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 01/16/19		32. SERVICE FACILITY LOCATION INFORMATION THE BACK NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	
		33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX/LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN	
3. PATIENT'S BIRTH DATE MM DD YY 07 05 1995 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR		7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR	
CITY EL PASO		CITY EL PASO	
STATE TX		STATE TX	
ZIP CODE 79928		ZIP CODE 79928	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 01/31/19		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 07 05 1995 M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL 431		15. OTHER DATE QUAL 454 MM DD YY 09 28 17	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M546 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
1 01 18 19 01 18 19 11 72146 A 2250 00 1 NPI 1356303150			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. CORDA005 143042	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 2250.00	
29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 01/31/19 DATE		32. SERVICE FACILITY LOCATION INFORMATION THE BACK NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	
33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.			



FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA																													
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicald#) (ID#/DoD#) (MemberID#) (ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN										3. PATIENT'S BIRTH DATE SEX MM DD YY 07 05 1995 M <input type="checkbox"/> F <input checked="" type="checkbox"/>																													
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																													
7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR										8. RESERVED FOR NUCC USE																													
CITY EL PASO STATE TX										CITY EL PASO STATE TX																													
ZIP CODE 79928 TELEPHONE (Include Area Code) ()										ZIP CODE 79928 TELEPHONE (Include Area Code) ()																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 02/20/19																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL 431										15. OTHER DATE QUAL 454 MM DD YY 09 28 17																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR ROBERT E URREA MDPA										17a. OB MDK4281TX 17b. NPI 1356303150																													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X										18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M24852 B. M79605 C. M7062 D. ICD Ind. E. F. G. H. I. J. K. L.										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
1 02 06 19 02 06 19 11 99215 25 ABC 500 00 1 NPI 1356303150										22. RESUBMISSION CODE ORIGINAL REF. NO.																													
2 02 06 19 02 06 19 11 20610 LT ABC 200 00 1 NPI 1356303150										23. PRIOR AUTHORIZATION NUMBER																													
3 N463323016505 ML4 02 06 19 02 06 19 11 J1100 ABC 40 00 4 NPI 1356303150																																							
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 <input type="checkbox"/> <input checked="" type="checkbox"/>										28. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) Corda005 143583 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and the made a part thereof.) SIGNATURE ON FILE SIGNED 02/20/19 DATE										28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use \$ 74000 \$																													
32. SERVICE FACILITY LOCATION INFORMATION THE BACK NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.										33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.																													



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

CARRIER →

PATIENT AND INSURED INFORMATION	
1	NAME OF PATIENT
2	DATE OF BIRTH
3	SEX
4	ADDRESS
5	CITY
6	STATE
7	ZIP
8	INSURED NAME
9	DATE OF BIRTH
10	SEX
11	ADDRESS
12	CITY
13	STATE
14	ZIP
15	INSURED NAME
16	DATE OF BIRTH
17	SEX
18	ADDRESS
19	CITY
20	STATE
21	ZIP
22	INSURED NAME
23	DATE OF BIRTH
24	SEX
25	ADDRESS
26	CITY
27	STATE
28	ZIP
29	INSURED NAME
30	DATE OF BIRTH
31	SEX
32	ADDRESS
33	CITY
34	STATE
35	ZIP
36	INSURED NAME
37	DATE OF BIRTH
38	SEX
39	ADDRESS
40	CITY
41	STATE
42	ZIP
43	INSURED NAME
44	DATE OF BIRTH
45	SEX
46	ADDRESS
47	CITY
48	STATE
49	ZIP
50	INSURED NAME
51	DATE OF BIRTH
52	SEX
53	ADDRESS
54	CITY
55	STATE
56	ZIP
57	INSURED NAME
58	DATE OF BIRTH
59	SEX
60	ADDRESS
61	CITY
62	STATE
63	ZIP
64	INSURED NAME
65	DATE OF BIRTH
66	SEX
67	ADDRESS
68	CITY
69	STATE
70	ZIP
71	INSURED NAME
72	DATE OF BIRTH
73	SEX
74	ADDRESS
75	CITY
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107	DATE OF BIRTH
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128	DATE OF BIRTH
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160	STATE
161	ZIP
162	INSURED NAME
163	DATE OF BIRTH
164	SEX
165	ADDRESS
166	CITY
167	STATE
168	ZIP
169	INSURED NAME
170	DATE OF BIRTH
171	SEX
172	ADDRESS
173	CITY
174	STATE
175	ZIP
176	INS

PHYSICIAN OR SUPPLIER INFORMATION

[illegible]